State of Wisconsin
Dept of Workforce Development
Equal Rights Division
Civil Rights Bureau

Family and Medical Leave Complaint

To be filled in by ERD
ERD Case Number
CR

For ERD Use Only

Personal information you provide may be used for secondary purposes. (See Section 15.04(1)(m) Wisconsin Statutes for details.)

Provide all information requested. Type or print In black Ink

1. Complainant Information

2. Respondent Information

Complainants First Name			Respondent name. (Name of the business you believe discriminated against you). If more than one respondent, list each separately.		
Complainants Middle Name or Initial					
Complainants Last Name					
Street Address			Street Address		
City	State	Zip Code	City	State	Zip code
Home Telephone Number ( )			Telephone Number ( )		
Work Telephone Number ( )			County of Employment		

3. Employment Status

I began working for this employer on: (month, day, year)
I have worked more than 52 continuous weeks for this employer at one or more of its locations or departments ☐ Yes ☐ No
I have worked at least 1000 hours for this employer during the last 52 weeks ☐ Yes ☐ No
A total of at least 50 people work for this employer at all of its locations ☐ Yes ☐ No

4. Previous Family and Medical Leave Use

I have used Family or Medical Leave during the current calendar year. ☐Yes ☐ No. If yes, how much leave did you take and for what reason? _____ _____
My employer has a poster displayed explaining my rights under the Wisconsin Family and Medical Leave Act ☐ Yes ☐ No

5. Present Leave Request. I have requested leave for the following reason (check appropriate answer)

☐ For the birth or adoption of my child (Family Leave)
☐ To Care for a seriously ill child, spouse, parent or parent-in law (Family Leave) Provide the name of person with the serious health condition Provide the person's relationship to you Describe the nature of their serious health condition

☐ For my own serious health condition (Medical Leave)

Describe the nature of your serious health condition

Note: If you took or requested leave because of your own or a family member's serious health condition, complete the enclosed Medical Release Authorization Form and return it with this complaint form.

I requested Family Leave for the birth or adoption of my child or to care for a seriously ill family member ☐ Verbally ☐ in writing on (month,_____ day,_____ year_____)	
Provide name of person you requested Family Leave from	Provide the title of the person
I requested Medical Leave for my own serious health condition ☐ Verbally ☐ in writing on (month, day, year)	
Provide name of person you requested Medical Leave from	Provide the title of the person
☐ I did not request Family or Medical Leave because I was unaware of my rights.	
How Much Leave did you request Hours _____ Days _____ Weeks _____	
I expected to be off work on the following dates	

6. Denial of Leave

I received notice that my leave request was denied on (month, day, year)
My employer denied my leave request because
My leave was not denied, but my rights may have been violated on (month, day, year):
I believe that my rights under the Family and Medical Leave Act have been violated in the following way:

By my signature below, I, or my authorized representative, state that I have read and understand this complaint and swear that it is true to the best of my knowledge and belief.

Signature of Complaint or Complainants representative	Date Signed

The Department of Workforce Development is an equal opportunity service provider. If you need assistance to access services or material in an alternate format, please contact us.

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FAMILY AND MEDICAL LEAVE COMPLAINT PROCESS INFORMATION

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Please complete and return this form with the signed Family and Medical Leave complaint form. This information is needed to help us more effectively handle your complaint.

Your last name	Your First Name	Your Middle Initial	Today's Date

Optional - used only to assure internal identification, accessibility and accuracy of your records.	Your Social Security Number __ __ __ - __ __ - __ __ __ __

Availability: - Please note below how you can be reached.
Important! You must notify the Department if you change your address or phone number. If we are unable to locate you, your complaint may be dismissed.

Provide the days and times that you are usually available to discuss your complaint.
Is there a telephone number where you can be reached during the day? ☐ Yes ☐ No
If yes, please provide the area code and number. ( )

In case we cannot reach you by telephone or by mail, please provide the name, address and telephone number of a person who does not reside with you but will always know where you live and how to reach you.

Name	Street Address		
City	State	Zip Code	Telephone Number ( )

Witnesses: Please list persons who have direct, first hand knowledge of what happened to you. Their participation is voluntary. Please provide their name, home address and telephone number.

Name	Street Address		
City	State	Zip Code	Telephone Number ( )
Name	Street Address		
City	State	Zip Code	Telephone Number ( )

Statistical Information

Complainant Sex: ☐ Male ☐ Female	Date of Birth

Complainant Race (check appropriate box or boxes):

☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Black or African American
☐ Asian ☐ White ☐ Unknown

Complainant National Origin or Ethnic background (check one):

☐ Hispanic or Latino ☐ Arab, Afghani or Middle Eastern ☐ Other

Mail your completed and signed complaint form to one of the following addresses:

EQUAL RIGHTS DIVISION
201 E WASHINGTON AVE ROOM 300A
PO BOX 8928
MADISON WI 53708

Telephone (608) 266-6860
FAX: (608) 267-4592
TTY: (608) 264-8752

EQUAL RIGHTS DIVISION
819 N 6TH ST
ROOM 255
MILWAUKEE WI 53203

Telephone (414) 227-4384
FAX (414) 227-4084
TTY (414) 227-4081